Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Lindhurst Lodge Residential Home

Lindhurst Road, Athersley North, Barnsley, S71 3DD

Tel: 01226282833

Date of Inspection: 21 July 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	A H Choudhry
Overview of the service	Lindhurst Lodge occupies a central position at Athersley North, approximately three miles from Barnsley town centre.There are shops, pubs, a post office and other amenities within the vicinity. The home is a purpose built, ex local authority care home providing personal care and accommodation for 37 older people. It is a two-storey building with a passenger lift. There is a small car park to the front, and large private gardens to the rear.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 21 July 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

An adult social care inspector carried out this inspection. At the time of this inspection Lindhurst Lodge was providing care and support to 21 people, some of whom had a diagnosis of dementia. We spoke with eight people living at the home, and three visiting relatives to obtain their views of the support provided. In addition, we spoke with the area manager and five members of staff about their roles and responsibilities.

We considered all the evidence against the outcomes we inspected to help answer our five key questions; is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

Below is a summary of what we found. If you want to see the evidence supporting our summary please read the full report.

Is the service safe?

We observed interactions between staff and people who lived at the home that were respectful and friendly. People were relaxed in the company of staff.

People we spoke with who lived at the home told us they felt safe living there. One person said, "It's as safe as your own house here." One relative said "It's such a relief to know that [family member] is safe and being well cared for. It's a weight off my mind."

Systems were in place to make sure that managers and staff learned from events such as

accidents and incidents, whistleblowing and investigations. This reduced the risks to people and helped the service to continually improve.

We found risk assessments had been undertaken to identify any potential risk and the actions required to manage the risk. This meant that people were not put at unnecessary risk but also had access to choice and remained in control of decisions about their lives.

The home had policies and procedures in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. Although no applications had been submitted relevant staff had been trained to understand when an application should be made and how to submit one. This meant that people would be safeguarded.

The service had completed enhanced Disclosure and Barring Service (DBS) checks, formerly known as Criminal Records Bureau (CRB) checks for all staff working at the home. This helped to protect people who were receiving a service.

Is the service effective?

We found people were provided with nutritious food. Some people required specialised diets for health or personal reasons and these were provided.

People told us they liked the food. Comments included: "It's all home cooked and always good. You never go hungry," "The food is good. You can eat as much as you like" and "I've got no complaints about the food. It's all good."

During our visit, we found people were provided with the support they needed. We found staff knew people well and were aware of their individual preferences.

Care files we checked confirmed that initial assessments had been carried out by staff before people moved into the home. This was to ensure the home was able to effectively meet the needs of the people. Specialist mobility and equipment needs had been identified in care plans where required.

We looked at the staff training matrix and found significant gaps in the training provided. When we looked at staff files we found certificates for training staff had completed which was not recorded on the training matrix. This meant there remained some gaps in staff training, but until a full audit of this was completed it was not possible to assess what the gaps were. Also staff had not been provided with a yearly appraisal. This meant there was a risk staff were not properly trained and their competency appraised.

We have asked the provider to tell us what they are going to do to ensure persons employed are receiving appropriate training and appraisal.

Is the service caring?

We observed warm and respectful interactions between staff and people who used the service as well as some good humoured banter. We found staff treated people in a kind manner.

People we spoke with who lived at the home told us they were happy living there. Comments included: "I like it here. I've been here a while and it's home for me," "It's a good place. The staff are nice and friendly and the food's good too," "I've not been here long, but I do like it here. People are friendly," "I'm quite happy here. No complaints from

me" and "I'm just here for respite (short term) care but I'd recommend it to anyone."

One relative told us, "The staff are all really good with [family member]. They are happy here. They all know me and I know all of them, which is nice."

Is the service responsive?

Staff told us the care and support provided was flexible to the person's needs and adjustments could be made where required. Staff said they informed the manager if they felt any change in needs was required and the support was reviewed. For example one relative told us, "My family member prefers a late breakfast and often doesn't eat at lunchtime but then they eat well at tea time and that suits them."

Several people, particularly men, told us there was not a lot for them to do during the day. Three people told us they did not like activities such as bingo or quizzes or music. One person said, "There's not much going on for me, so I watch TV most days. It does get a bit boring sometimes." One person told us they preferred to stay in their bedroom all day and preferred to socialise out of the care home.

We observed one person who used the service preferred to spend some of their time sitting on the floor. We noted that this person was not always in the view of care staff. We saw other people had to manoeuvre their walking frames around this person at times in narrow corridors. This meant there was a risk of people using the service falling. This had not been identified and action taken to ensure their safety and welfare.

There were no outstanding complaints about the service. People who used the service said if they had any worries they would take their concerns to a member of staff or to the managers'. One person said, "You can talk to anyone here. I know they'd sort anything out for you."

Is the service well-led?

The service worked well with other agencies and services to make sure people received their care in a joined up way.

People who used the service and their relatives said they could not recall being asked to attend residents' or relatives' meetings. The area manager said a relative meeting had been arranged but no one had turned up. We saw the poster that had been on display in the home advertising this.

Information collated by CQC evidenced that the service had not reported the death of any person who used the service since April 2013. It is a legal requirement for services to inform CQC about the death of a person who uses the service. If services do not inform CQC they are at risk of receiving a fine or being prosecuted.

The service carried out a yearly 'Quality Assurance Survey'. Feedback was sought by way of customer satisfaction surveys sent to people who used the service, their relatives and friends, staff and healthcare professionals. This showed people had the opportunity to put their views across.

The area manager explained the systems in place to assess and monitor the quality of service provision. The area manager said audits were completed each month and covered many areas, for example, infection control, environment, medication, food hygiene and

care plans. We checked the audits and found they had not been completed since March 2014.

We have asked the provider to tell us what they are going to do to ensure the quality of the service is monitored so that any risks relating to the health, safety and welfare of people are identified and managed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 26 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with eight people who used the service in the communal areas of the home and in their own rooms. Comments from people included, "I like it here. I've been here a while and it's home for me," "It's a good place. The staff are nice and friendly and the food's good too," "I've not been here long, but I do like it here. People are friendly," "I'm quite happy here. No complaints from me" and "I'm just here for respite (short term) care, but I'd recommend it to anyone."

We observed interactions between staff and people who lived at the home that were respectful and friendly. People were relaxed in the company of staff. Staff spoke courteously with people and knew people's preferences and family background.

People told us they liked the staff. One person said, "The staff are all lovely people. They do help you when you need it, but on the whole they let you get on with things." Another person said, "The staff are all kind. I like them all."

One relative of a person who used the service said, "The staff are all really good with [family member]. They seem happy here. They all know me and I know all of them, which is nice."

We observed people were allowed to be as independent as possible, for instance with their mobility. We saw care staff bringing walking frames to people in their chairs to allow them to walk to the dining room. Two people left the home regularly on their own to socialise with friends. We spoke with one person in their bedroom who had tablets on their bedside table at around 11am. This person told us they were pain killers and they only had to take them if they had pain. They said they would tell staff at lunchtime if they had taken them.

People we spoke with told us they received care and support when they needed it. One person said, "I wash and dress myself. I just need help with remembering to take my

tablets." Another person said, "I've got a buzzer in my room, but I never use it because I can do everything for myself."

People we spoke with told us they could get up and go to bed when they liked. One person said, "I like to go to my room and watch TV after tea. I can get myself ready for bed." Another person said, "I don't get up very early, so I have a late breakfast."

We saw most people spent the day in the two communal lounge areas and people had their preferred chairs. We observed that TVs were playing in both lounges. A few people preferred to sit in the entrance area. We noted that modern music was playing in the entrance area. We were not able to communicate with people in the entrance area so they weren't able to let us know if they liked the music. Three people we spoke with said they preferred to spend their time in their bedrooms and that this was respected by the staff.

Short activity sessions were held every week day in the morning and afternoon. On the day of our inspection some ladies had their nails painted and hands massaged by the activities co-ordinator in the morning. There was an oral quiz and sing-a-long session in the afternoon. We saw several people did not have the mental capacity or communication ability to contribute to the quiz and there was no recorded music to sing along to.

We observed care staff were not assisting with the activity session in the afternoon. After 2pm when the activities co-ordinator left, several people were falling asleep in their chairs in the lounge. There were no formal activity sessions provided at weekends.

Several people, particularly men, told us there was not a lot for them to do during the day. Three people told us they did not like activities such as bingo or quizzes or music. One person said, "There's not much going on for me, so I watch TV most days. It does get a bit boring sometimes." One person told us they preferred to stay in their bedroom all day and preferred to socialise out of the care home.

We saw that one person preferred to spend some of their time on the floor. We saw this person was not always in the view of care staff. We saw other people had to manoeuvre their walking frames around this person at times in narrow corridors. This meant there was a risk of people using the service falling. This had not been identified and action taken to ensure their safety and welfare.

We examined five people's care files. All the care files contained information about the person's biography, physical, medical and personal support needs. They also included people's likes, dislikes and preferences. All the care files had a range of individual risk assessments. There were clear links between the risk assessments and the care plans. All the care plans were reviewed at least each month, but more frequently if people's needs changed.

There was evidence in the care files that a range of healthcare professionals were involved in supporting staff to meet the needs of people as required. The care files recorded information provided by relatives which was reflected in the care plans as appropriate.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We found people were provided with nutritious food. Some people required specialised diets for health or personal reasons and these were provided.

People told us they liked the food. Comments from people included, "It's all home cooked and always good. You never go hungry," "The food is good. You can eat as much as you like" and "I've got no complaints about the food. It's all good."

One relative of a person who used the service said, "My [family member] has a late breakfast and often doesn't eat at lunchtime but then they eat well at tea time and that suits them."

We saw that a hot lunch was served every day. There was one main option for the main meal and pudding every day, but we were told people could choose from other options if they did not like the main choice. On the day of our visit we saw that everyone was served the hot meal and that everyone (apart from one person who was asleep and did not want lunch when they woke up) ate their meal. The meal looked appetising and was well presented.

We observed one person with learning and communication needs was served a hot meal of Lancashire hot pot, followed by sponge and custard. This person had a plate guard and was offered a spoon, but they ate the whole meal with their fingers. We saw staff did not assist the person to eat. We looked at the person's care plan and it stated if the persons cutlery was placed in their hands they would be able to eat independently. When we asked staff about this they said the care plan information was out of date and the person now required assistance with eating. Staff were unable to clarify why no one had assisted the person to eat their lunch.

The provider may find it useful to note this person was not supported to meet their eating needs with sensitivity and respect for their dignity.

Three people chose to eat their meals in their rooms and their meals were served at the same time as others so they were hot.

People told us there were plenty of drinks served during the day. We observed the

refreshment trolley being taken around in the morning and afternoon. We saw hot drinks, cold drinks, cakes and fresh fruit were available on the trolley.

We spoke with the cook. They showed us the four weekly rotating menus. These provided a good variety and choice of food, which included fresh fruit and vegetables. The cook was very knowledgeable about the likes and dislikes of people and had up to date records of what people's diet preferences were.

People's care records we checked showed their food likes and dislikes were recorded and details of 'special diet' requirements for people were identified.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Without exception all people spoken with said they felt safe in the home and that they had no concerns about ill treatment of themselves or others. One person said, "It's as safe as your own house here." One relative said, "It's such a relief to know that [family member] is safe and being well cared for. It's a weight off my mind."

People who used the service told us that if they ever had a problem, such as not feeling safe, they would speak to any of the care staff and they were confident they would sort the problem out. One person said, "You can talk to anyone here. I know they'd sort anything out for you."

The home had policies and procedures in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. Although no applications had been submitted relevant staff had been trained to understand when an application should be made and how to submit one. This meant that people would be safeguarded.

Senior staff spoken with during our inspection confirmed there was a process in place to ensure any concerns raised were reported as incidents to safeguarding. This meant immediate action was taken to ensure any potential abuse was identified and stopped.

We spoke with five staff. They were aware of adult safeguarding policies and procedures and what action they should take if they saw or suspected any abuse.

The provider may find it useful to note the training matrix we saw was not up to date and senior managers' were therefore unable to confirm if all staff had received training in safeguarding adults.

The service had completed enhanced Disclosure and Barring Service (DBS) checks, formerly known as Criminal Records Bureau (CRB) checks for all staff working at the home. We saw evidence of this. This helped to protect people who were receiving a service. The manager confirmed to us that no members of staff were allowed to commence working with people until their DBS check had been received. The manager

was aware that if a person's DBS check was returned with information recorded, they must carry out a risk assessment to show that they had considered the results of the DBS check and all other information they had about the person before making the decision to employ the person or not.

The service had a policy and procedure in relation to supporting people who used the service with their personal finances. The home managed money for some people. We saw the service had a system in place to manage each person's money and a sample of documentation was reviewed to demonstrate operation of the system. We saw finance sheets for money put into and taken out of people's accounts had been signed by two members of staff. We found that a company representative went into the service to carry out a check of finances every three months. These visits were unannounced. Previous checks of finances by the company representative had not identified any issues or concerns.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with five members of staff. One member of staff had recently started working at the home following completing a 'Future Carers' course with Barnsley Local Authority. The staff member told us they had worked at the home on placement whilst undertaking a three week rapid course. The course had included training courses in all mandatory subjects for example, moving and handling, food safety, first aid and health and safety. The care worker told us during the three weeks they had worked supernumerary to numbers and alongside a more experienced member of staff.

The home manager had a 'Training Matrix' which showed the training staff had undertaken. We saw gaps in the training matrix. The mandatory training programme covered all of aspects of training including health and safety, food hygiene, infection control and safeguarding. Specialist topics were also included for example challenging behaviour and dementia. Some staff were not recorded as completing training in mandatory subjects since 2010.

We looked at staff files and found some certificates for training they had completed, which were not recorded on the training matrix. This meant it was not possible to confirm what training staff had completed. Staff that we spoke with were unable to remember what training they had completed over the past year. We asked the area manager what their policy stated regarding updating and refresher training. They said some training topics were provided yearly for example medication and others were provided every two to three years. This meant staff had not been provided with updated and refresher training as per the homes policy.

We spoke with one senior member of staff who had completed their training in mandatory subjects prior to working at Lindhurst Lodge. We saw copies of certificates they had brought with them, some dated back to 2010. They said since they had commenced work at Lindhurst Lodge they had only completed training in Dementia and Medications. They said they had not received any updated or refresher training since starting at Lindhurst Lodge.

One member of staff spoken with told us they didn't think the manager of the home always took action when they reported things to her. They said they felt unsupported by the manager and that they were not enabled to acquire further skills and qualifications that were relevant to their work.

Staff we spoke with said they had received formal one to one supervision from the home manager approximately once every three months. Staff told us they had not been provided with a yearly appraisal. Staff appraisal is a way of developing staff through a regular system of support that promotes their development and knowledge. This meant staff were not properly supported, trained and appraised.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The home manager was not working on the day of the inspection. She had been in post for 15 months and had not applied to be registered with CQC. Two senior managers that we spoke with on the day of the inspection told us they believed the manager had applied to be registered. We had not received any application. We have formally notified the provider of this and will continue to monitor the situation until a manager becomes registered,

We looked at a sample of the service's policies and procedures, for example the health and safety policy. We found the policies and procedures to be detailed, clearly written and easy to understand. The policies and procedures had been reviewed and updated as necessary.

Prior to the inspection information collated by CQC evidenced that the service had not reported the death of any person who used the service since April 2013. During the inspection the area manager confirmed to us that three deaths had occurred at the home since April 2013 and we had not been notified of these. It is a legal requirement for services to inform CQC about the death of a person who uses the service. If services do not inform CQC they are at risk of receiving a fine or being prosecuted.

The regional manager explained the systems in place to assess and monitor the quality of service provision. They said the internal auditing of the service covered many areas, for example, infection control, environment, medication, food hygiene and care plans. We saw copies of the audits which were expected to be completed each month by the manager. We found no audits had been completed since March 2014. Incidents and accidents had not been analysed to identify themes and trends so that an effective action plan could be put in place. This meant regular assessment and monitoring of the service had not taken place. Senior managers were not aware of this. which could have put the health, welfare and safety of people using the service at risk.

A complaints procedure was in place so that people could voice any concerns. We saw

information about how and who to complain to on display around the home.

People we spoke with told us if they had any worries they would take their concerns to a member of staff or speak with their relatives.

People who used the service and their relatives said they could not recall being asked to attend residents' or relatives' meetings. The area manager said a relative meeting had been arranged but no one had turned up. We saw the poster that had been put up on display advertising this.

Staff told us they had regular meetings with the home manager. The last staff meeting was in May 2014. We saw notes had been made at this meeting but no minutes had been written and staff told us they could not remember seeing or being provided with a copy of the minutes. This was also the case for the meeting held in February 2014. This meant staff did not have information available of the discussions that had taken place and any actions they needed to take.

People who used the service, healthcare professionals and staff had been given 'Customer Satisfaction Surveys' to complete in April 2014. People were asked their opinions about such things as the environment, social activities, food and personal care and support. We saw the returned surveys which showed people rated the service as either good or very good in most areas. The area that most people were less satisfied with was activities. The area manager said a report detailing the findings of the 'Customer Satisfaction Survey' would be completed when all the surveys had been returned. The area manager was aware that surveys to relatives and advocates had not been sent out and they were in the process of doing this.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Suitable arrangements were not in place to ensure people employed were receiving appropriate training, professional development and appraisal. Regulation 23 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regular assessment and monitoring of the quality of the service did not take place which could put the health, safety and welfare of people using the service at risk. Regulation 10 (1).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 26 August 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will

This section is primarily information for the provider

report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk